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Massachusetts Office for Children

Interagency Team Report FY'86

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**INTERAGENCY TEAM PROGRAM
FY 1986**



THE INTERAGENCY TEAM PROGRAM

Background

In July, 1983, the Legislature enacted Chapter 288 of the Acts of 1983 amending Chapter 28A of the Massachusetts General Laws. Passage of this law gave statutory authority to the Inter-agency Team and required the Director of the Office for Children (OFC) to convene and chair interagency children's services teams. According to the statute, these teams are created to determine "which agency shall provide or contract for appropriate services to a child in cases where disputes arise among agencies over the delivery of services to a child or when such services are not being provided to a child."

How Team Works

Cases that come before Interagency Teams are those which cannot be resolved at the local level because an agency is unable or reluctant to accept responsibility for a particular case. The Interagency Team provides a process for assuring that children receive needed services.

After the area-based OFC Child Welfare Specialist (advocate) exhausts all potential resources and avenues for resolving a case at the local level, cases are referred to a Regional Interagency Team (RIT). This Team level brings together regional representatives from state agencies responsible for delivering services to children. Team agencies specifically named by the statute are as follows:

- * Department of Mental Health (DMH)
- * Department of Public Health (DPH)
- * Department of Public Welfare (DPW)
- * Department of Social Services (DSS)
- * Department of Youth Services (DYS)
- * Massachusetts Commission for the Blind (MCB)
- * Massachusetts Rehabilitation Commission (MRC)
- * Department of Education (DOE)

All of the agencies operate under the Commonwealth's Executive Office of Human Services (EOHS), except for the Massachusetts Department of Education.

If resources cannot be identified and resolution achieved at the regional level, cases are escalated to a similarly constituted team at the statewide level. Central Interagency Team (CIT) members represent the Commissioners of those same agencies that make up the RITs. If an agency fails to provide a child the services directed by CIT, the case is referred to the

Secretary of Human Services. If the secretary finds that the Team's decision is reasonable and within the jurisdiction of the designated agency, the secretary is required by statute to direct the agency to comply with the decision.

For a child's case to be presented to Team, it must first be referred to a child advocate in one of OFC's 43 area offices. Cases move up the system only after the advocate and his/her supervisor determine that every channel of the human services and education system has been explored at the area level for this child without success. In about half of OFC's 43 areas, this is done through Area Teams which are constituted in a manner similar to the Regional and Central Teams.

Team meetings provide a forum where interagency disputes and other problems can be resolved. They serve to identify gaps in services, as well as deficiencies in funding, and point out the need for new or expanded treatment resources.

Team Cases

In FY '86, seven Regional Interagency Teams acted on 174 cases. Individual RITs intervened in as many as 39 cases during the year or as few as 16. For a complete breakdown of Regional Team case-loads in FY'86 see the chart below.

Of the 174 Regional Team cases, 75 were escalated to the Central Team and four to the Secretary of Human Services. The percentage of cases resolved at Central Team during FY'86 remained consistent with previous years at 67 percent.

An analysis of the FY'86 data will attempt to answer the following question: Why does a particular child's need for services require commissioner-level intervention for resolution? Answering this question is critical to individual children and those responsible for making the service delivery system work effectively.

Nature of the Cases

Children brought to the CIT typically present complex diagnostic profiles. Without exception, these children need extensive services. Children rarely had a single disorder and their requests for service were almost entirely for residential placements. In addition to being quite costly, residential placements for these children are often difficult to identify and sometimes do not exist.

A summary of FY'86 service requests reviewed by CIT follows.

FY'86 SERVICE REQUESTS

<u>Residential Services</u>	<u>Number of Requests</u>
Placement for Mentally Retarded/ Multiply Handicapped	27
Secure In-patient Setting for Mentally Ill and Dangerous	15
Program for Emotionally Disturbed/ Mentally Retarded	7
Placement for Mentally Ill	6
Placement for Autistic	6
Placement for Head Injured	5
Hospitalization for Emotionally Disturbed/ Mentally Retarded	5
Respite Placement for Multiply Handicapped	2
<u>Other Services</u>	
One to one Staffing	1
Day Program for Deaf/Emotionally Disturbed Student	1
TOTAL	75 Cases

The following case example illustrates the complexity of Team cases.

Case Example

Tim, an 11 year-old, was diagnosed as having a bilateral, sensorineural, severely profound hearing loss. In addition, his behavior disorder included assault and impulsive running. Tim attended the a school for the deaf for six years. He was then discharged, however no other program was available. A hearing at the Bureau of Special Education appeals in 1983 had determined that Tim did not require a residential program to make educational progress. The request to the Team was for technical assistance in identifying a day school program for Tim, since no school would accept him primarily due to his behavior. Various alternatives were tried, including an classroom for the emotionally disturbed in the public school with a teacher for the hearing impaired and a collaborative program. Finally, an in-home program set up by a consultant from Boston University, which eventually was moved from the home setting to a school for the deaf, was successful.

Barriers to Service

The reasons children fail to receive needed services at the local level fall into three categories:

- * State agencies are unable to agree on which agency has responsibility for providing services to the child;
- * Agencies agree on responsibility, but the agency or agencies are unable to fund the particular service;
- * Agencies agree on responsibility and funding has been identified, but no existing program has the capacity to provide the necessary service.

When reviewed for the primary barrier to service, one-third of the FY '86 CIT cases fall into each of these three categories.

As in previous years, some cases fell into all three categories. For example, a single case presented a question of agency responsibility which was resolved only to expose a funding barrier and eventually the third impediment based on the availability of an appropriate program.

Cases Presented to Team Because Agencies Dispute Responsibility

During FY '86, 24 cases were escalated to the Central Interagency Team for resolution of agency disputes. Three categories of children were most likely to be affected: those who were mentally retarded and multiply handicapped, those who were mentally ill, and children with head injuries.

Mentally retarded children were most likely to be rejected by all agencies for residential services. Regardless of age or family situation, the Department of Social Services refused five requests for out-of-home placement, even when another human services agency was willing to share the responsibility. This also happened in cases where clients had a dual diagnosis of mental retardation and emotional disturbance. In addition, in certain areas of the state, the Department of Mental Health refused to provide residential services for mentally retarded children. Further, the Department of Public Health, when requested to provide residential placements for multiply handicapped children under its Services to Handicapped Children Program also declined to assume responsibility prior to involvement by the Central Team.

The Central Team in FY '86 found that agency disputes also affected mentally ill children. Unlike previous years, there were no disputes between DMH and the Department of Youth Services. Presumably, this occurred because Intensive Residential Treatment Programs (IRTPs) were available to appropriate DYS clients beginning in October of 1985. DSS and DMH however, disagreed on responsibility in five cases. DSS referred children who needed group care to DMH, especially if the children were diagnosed as having a major depressive illness. Unless the child required inpatient treatment, Team found DSS responsible for these residential placements.

A third category seen by the Central Team--children with head injuries--present questions concerning agency mandates. Despite the creation of the Massachusetts Rehabilitation Commission's Statewide Head Injury Program (SHIP), the responsibility of other agencies, particularly DMH, for these children is unclear. Children with head injuries, like those who are mentally retarded or mentally ill, also pose questions regarding the responsibility of Local Education Authorities (LEAs) to provide special services. (LEA is a term used to refer to a local school system.)

Agency disagreements on Central Interagency Team cases shifted as the cases progressed. Representatives of agencies at an area level presented inconsistent views on their agency mandates. When designated by CIT, most agencies agreed to assume responsibility for particular services. Only four cases referred to the Central Team during FY '86 required review by the

Executive Office of Human Services for final determination of agency responsibility.

The chart below shows the percentage of cases assigned to state human services agencies by Team in FY'84, FY'85, and FY'86.

AGENCY RESPONSIBILITY FOR CASES

AGENCY/DEPARTMENT	FY'86	FY'85	FY'84
Mental Health	68%	73%	70%
Social Services	32%	35%	30%
Public Health	11%	5%	3%
Local Ed. Authorities	11%	0%	NA
Education	7%	6%	5%
Youth Services	5%	6%	5%
MA Rehab. Commission	5%	3%	0%
MA Commission for the Blind	4%	4%	2%

NOTE: Costs per case are frequently shared among agencies thus total exceeds 100 percent.

Cases Presented to Team Because of Funding Problems

Of the 25 cases in which the lack of funds became the major roadblock to services, DMH was identified as responsible for 20. In contrast, DYS, DSS and DPH each cited funding as a barrier in only a single case per agency. MRC/SHIP and MCB each identified funding shortages as the barrier to service in two cases. In two cases of joint responsibility, both agencies had funding problems.

Of these same 25 cases, 22 required intensive services which are expensive. In 11 cases, the service needed was hospitalization; an additional 11 requests were for residential placements. In three of these cases, children were able to be served in less restrictive settings--one in a staffed apartment and two in specialized home care. Given the expense associated with these requests, it is not surprising that services were not accessible prior to the involvement of Team.

Cases Presented to Team Because No Program is Available

In one-third of the 75 Central Team cases, agencies were unable to find an appropriate program to provide the needed service. Despite an agency being identified and willing to fund services, appropriate programs were not available. All agencies were faced with cases of this nature. Reasons programs rejected children varied. Particular medical disorders such as Prader-Willi syndrome or Schilders disease made children difficult to place. Two adolescents were excluded from programs because they were Hepatitis B carriers.

Disputes Escalated by Central Team to EOHS

During FY '86, EOHS received four requests from the Central Team for final determination of agency responsibility. Two cases had been assigned by the Team to DPH, and one to MRC's Statewide Head Injury Program (SHIP). All of these cases involved multiply handicapped individuals seeking residential placements. In each of these cases, the agency designated by the Team disagreed that it was responsible for providing services. A fourth escalation to EOHS involved an adolescent without appropriate services due to the lack of a program; agency responsibility was not at issue.

One case involved a 17 year-old male with Schilder's disease, a progressive neurological disorder. The Central Team found the Departments of Mental Health and Public Health jointly responsible for the residential component of this adolescent's program. The Department of Public Health disagreed citing his age and behavioral problems. EOHS assigned full responsibility for residential expenses to the Department of Mental Health.

In the second case, a 20 year-old female with aphasia, hemiparesis and mental retardation as a result of a head injury was assigned by the Central Team to MRC/SHIP. The assignment was temporary while the client's educational plan was being appealed. EOHS determined that the Department of Mental Health was responsible for the interim assignment, since the client's condition was similar to that of other mentally retarded DMH clients.

In the third disputed case, both EOHS and Central Team agreed that a 16 year-old girl with congenital encephalopathy, spastic quadriplegia and scoliosis was the responsibility of the Department of Public Health and Mental Health. DPH is currently working with DMH and a vendor for specialized home care to identify an appropriate placement.

Geographic Distribution

In looking at the parts of the state from which Central Team cases originated, there is a wide variance in numbers found. There are many possible reasons for these patterns:

- * Areas and regions differ demographically;
- * Agencies do not allocate funds to regions and areas on an equitable basis. Access to funds dramatically affects the amount of time and effort needed to resolve a case;
- * All areas do not have a uniform core or consistent base of treatment services.
- * The degree of interagency communication and cooperation varies from one area of the state to another. When agencies work well together at the area level, cases are less likely to require Team intervention to address questions of responsibility.

Summary

This overview of the cases presented to the Central Team in FY'86 suggests why certain cases require regional or Commissioner-level intervention to arrive at a successful resolution. First, all of the cases involve children with complex diagnostic profiles. These children have multiple disabilities and require intensive treatment programs. Both public agencies and private providers have difficulty responding to individual children with such unusual and high levels of need, especially when the scope of need exceeds the purview of one agency. Secondly, the ways in which these cases become "stuck" suggest that local resolution is not possible. Agency disputes arise because statutory mandates and agency eligibility criteria are not always drafted or interpreted to address the complex needs of these specific children. Finally, funds and programs for these special populations are often not available locally.

The charts presented below summarize the distribution of Central and Regional Interagency cases according to region of origin, and show the outcome of regional caseloads.

CENTRAL INTERAGENCY TEAM CASELOAD - FY'86

ORIGINATING REGION	TOTAL CASES	PENDING FY'85	SERV. FROM REG. FY'86	RESLVD	PENDING 6/30/86 AT CIT	WITHDRAWN	PENDING 6/30/86
I	7	3	4	3	2	1	1
II	6	4	2	5	1	0	0
III	7	1	6	7	0	0	0
IVA	6	2	4	5	1	0	0
IVB	28	8	20	19	7	1	1
V	7	1	6	5	1	1	0
VI	14	6	8	6	5	0	3
TOTALS	75	25	50	50	17	3	5

REGIONAL INTERAGENCY TEAM CASELOAD - FY'86

REGION	TOTAL CASES	RESLVD	PENDING 6/30/86	WITHDRAWN	ESCLTD TO CIT
I	16	5	7	0	4
II	20	8	7	3	2
III	32	10	12	4	6
IV A	20	8	6	2	4
IV B	39	11	7	1	20
V	29	11	11	1	6
VI	18	6	4	0	8
TOTAL	174	59	53	11	50

Recommendations

The nature of Team cases, the barriers they identify and the solutions that are worked out at the area, regional and central levels suggest some courses of action.

SERVICE BARRIERS	FY'86	FY'85	FY'84
Agency Disputes Responsibility	33%	48%	38%
No Funding	33%	44%	24%
No Program	33%	30%	38%

NOTE: Cases recorded in FY'84 and FY'85 show multiple barriers on each case so that total exceeds 100 percent. Cases in FY'86 were categorized by the primary barrier to service.

Funding

Services for mentally ill and/or mentally retarded children need to be adequately funded. Over 70 percent of the cases requiring Central Team intervention are the responsibility of the Department of Mental Health. These cases come to Team because DMH's Individual Service Fund is inadequate to purchase the needed services. In FY '87, additional funding is needed for in-patient services and residential programs. A Children's Reserve Fund should be re-established for Team cases.

Program Development

Even when funding is made available, programs do not currently exist to serve certain populations. There are insufficient residential resources for multiply handicapped children. Although the Department of Public Health is developing two new programs in FY '87 to serve a total of eight multiply handicapped children, additional resources are needed.

Team cases also point to a need for: additional 766-approved schools for certain handicapped students. School programs were not available for a deaf/ emotionally disturbed student, a compulsive fire setter, two students identified as carriers of Hepatitis B, and seven autistic or emotionally disturbed/mentally retarded adolescents. The planned expansion of two private

schools in FY '87 will partially address this need. Until 766-approved placements are available, the Department of Education will need to assist local school systems with individually approved programs.

Despite the creation of new programs for adolescents who require short term and long-term psychiatric hospitalization, there is an immediate need for an additional long-term treatment facility.

Programs for adolescents with head injuries are insufficient. Three clients have been sent to facilities located outside of Massachusetts for necessary services, requiring families to travel long distances to visit their children and meet with program staff.

Programs for clients with a dual diagnosis of emotional disturbance/mental retardation need to be developed. Currently there is only one resource for the most severely disabled in this diagnostic group. It is the Developmental Disabilities Unit at Bradley Hospital in Providence, Rhode Island.

Programs need to be developed in the Commonwealth for juvenile sex offenders. The cases seen by the Central Team originated in several agencies (DSS, DYS, DMH). However, none of these agencies offer or fund an adequate number of treatment programs. In most of these cases, clinicians have recommended secure treatment programs while some have suggested that offenders require a segregated program. Few residential programs exist which have treatment components specifically for juvenile sex offenders. Early treatment for this population is vital; research indicates that most adult sex offenders began offending as juveniles.

Respite service's for multiply handicapped children need to be expanded. Although the number of respite requests at Central Team was not high, significant amounts of time and effort were required to locate services for certain children. These children included one with a severe behavior disorder, one who was medically disabled, and one who needed interpreters.

Finally, residential facilities generally need to be more responsive to the needs of older adolescents. It can be expected that older severely impaired children will be rejected by several programs and may even be at risk in interim, inappropriate placements such as home, a respite care facility or a hospital. Program development should focus on the needs of this population.

Policy Development

The absence of clear agency guidelines and policies often causes inappropriate factors to enter into decision-making and increases, rather than decreases, interagency disputes. Policy decisions in the following areas would do much to reduce the frequency of disputes regarding the provision of services to certain populations of children.

* Multiply Handicapped Children

Who is responsible for providing residential services and for what categories of multiply handicapped children?

In FY'86 there were 27 requests submitted to the Central Team for residential services for multiply handicapped, mentally retarded children and two requests for respite placement for this population. These cases represented 39 percent of all the cases heard at Central Team. The Central Team assigned the Department of Public Health responsibility for 11 percent of these cases pointing to the necessity of determining:

*the responsibility of DPH for serving the severely handicapped of this population; and

*the need to assign other agencies to share in the provision of services to certain groups due to the multiplicity of their handicaps.

* Mentally Retarded and Mentally Retarded/Emotionally Disturbed Children

What are the respective roles and responsibilities of DMH, DSS, DMR and local school systems for this category of children?

In FY'86, 39 of the 73 requests for residential placements involved mentally retarded children. The largest number were mentally retarded multiply handicapped (27), followed by mentally retarded emotionally disturbed (12). The mentally retarded 19 to 22 year-olds with physical or behavioral problems are especially at risk of remaining in interim, often inappropriate placements for long periods of time. This occurs because 18 to 22 year-olds are not yet eligible for adult services from DMR, and DSS is less likely to offer services to these young adults. Their needs however, do not "go on hold" until they are 22.

Summary

Although these children appear numerically insignificant, the exceptional nature of their needs demands our immediate attention. New programs must be funded and policies must be clarified on which agencies are responsible for developing and funding these programs in order to remove the barriers to as full a life as is possible for these children.

Individual children with particularly complex or rare disorders will always challenge our service delivery system. Through Team we can not only identify these small populations and bring them to the attention of policy makers so that solutions can be found to address their needs in a systemic way, but also provide an opportunity for representatives of the human services and educational systems to come together to cooperatively devise an appropriate plan for addressing the individual child needs.

Conclusion

An examination of cases handled by OFC's Interagency Team suggests that while certain problems have been addressed, other problems persist and new issues are emerging. The greatest number of requests to CIT in FY '86 were for residential placements for the multiply handicapped and secure inpatient units for severely disturbed adolescents. Planning efforts are underway in FY '87 to address the first, and much headway was made during FY '86 on the second. Emerging groups waiting for adequate services are youth with a combined diagnosis of mental retardation and emotional disturbance, clients with head injuries, juvenile sex offenders, and older adolescents.

Some individual children with particularly complex or rare disorders will continue to challenge our service delivery system. The Team Program was created to assist these children in obtaining needed services and will persist in this endeavor.

In addition, the Team Program provides a mechanism for identifying small populations with unusually complex service needs. It also acts as a conduit for bringing these groups to the attention of state policy-makers so that systemic remedies can be developed and instituted.

FY '86
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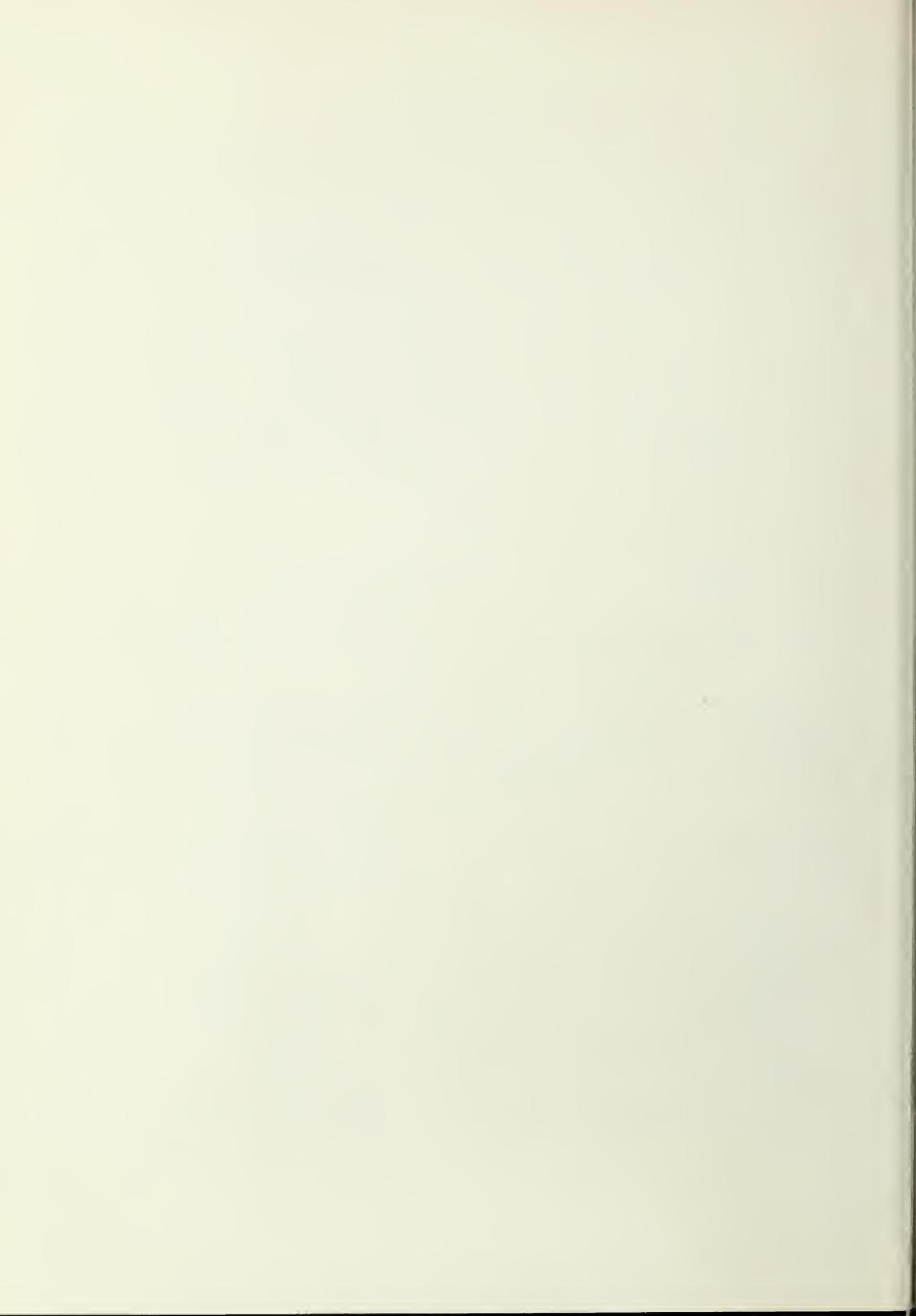
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Massachusetts Office for Children

HELP FOR CHILDREN AND INTERAGENCY TEAM REPORT FY'87 & FY'88

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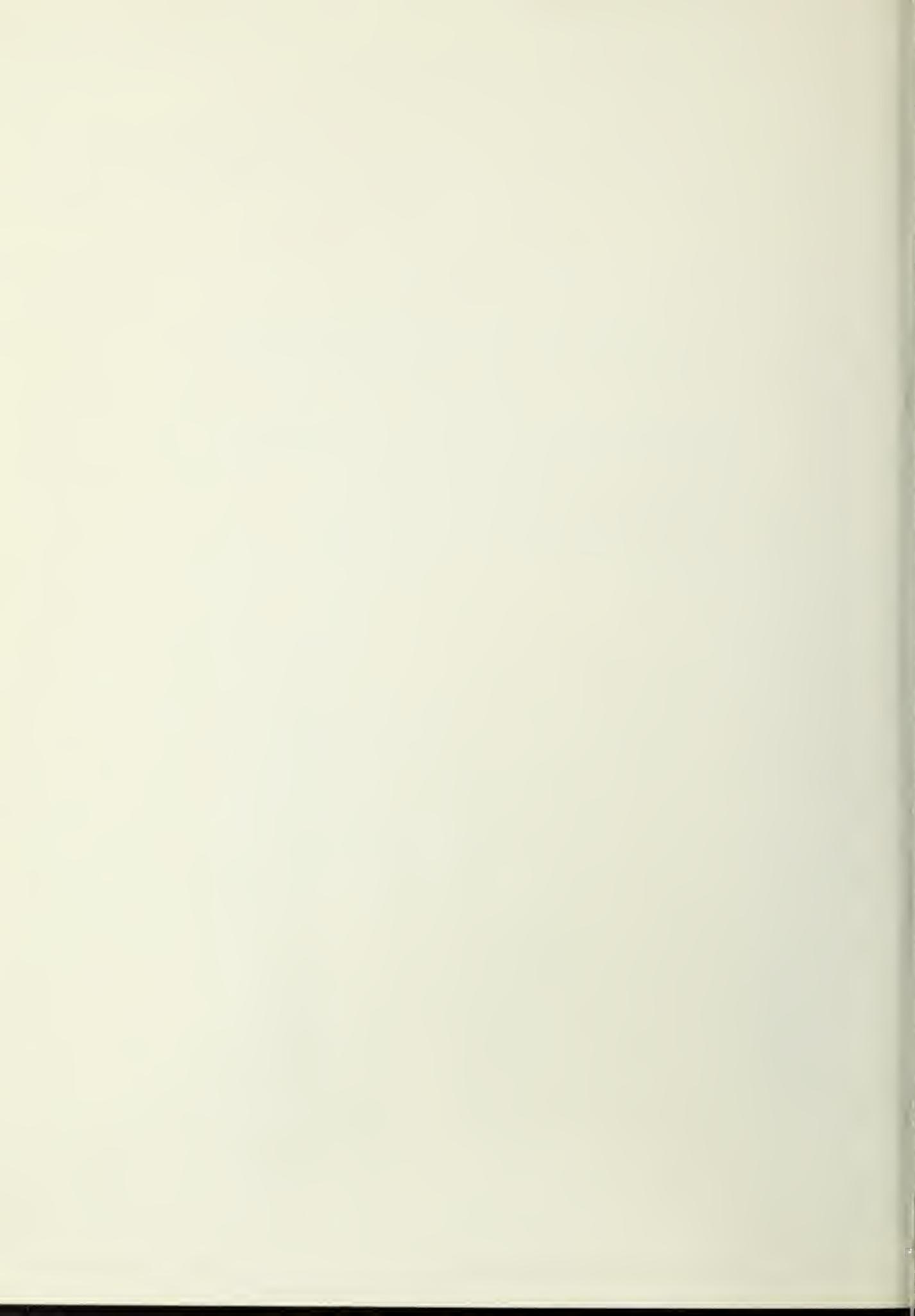


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INTRODUCTION AND EXECUTIVE SUMMARY

OVERVIEW

Children's services are delivered in a philosophical context that shifts over time. Family support, which emphasizes prevention and the goal of helping families to protect and nurture their children, is a philosophy now widely discussed nationally and in Massachusetts. This report is intended to initiate a discussion within the Office for Children and with agencies that serve children and families about how we can we help families build on their own strengths to care for their children.

The Massachusetts Office for Children's (OFC) Help for Children (HFC) program provides information, referral services, and individualized advocacy services for thousands of children and families through a network of local offices across the state. If local action cannot resolve a problem, cases are referred to regional and central interagency teams composed of representatives from state agencies that serve children. Through this process, HFC identifies emerging social issues as well as problems within the children's services delivery system.

Help for Children advocates responded to an average of 74,300 requests for information and referral a year from parents, professionals, children and others during fiscal years 1987 and 1988.¹ In an average of 6,800 cases each year, HFC advocated locally on behalf of children and families with schools, state and community agencies. The Central Team acted to resolve an average of 54 cases a year.

This report highlights what children need from a family support perspective as documented by HFC during 1987 and 1988. HFC data confirm the arguments of family support advocates who believe that the children's services system needs redirection—toward prevention, early intervention and helping families care for their children in their own homes. At the same time, HFC emphasizes the need for a continuum of services, including out-of-home residential programs.

Data from 1987 and 1988 HFC cases requesting services for individual children indicate the following:

¹ Throughout this document, "1987" and "1988" refer to fiscal years 1987 and 1988—July 1, 1986 through June 30, 1988.

- Cases typically involve children who are at risk. About 75 percent of these children have at least one disability.
- Cases usually involve children who have "fallen through the cracks" of the children's services delivery system. Advocacy services are requested after crises develop or problems become chronic. Children served by HFC are most likely to be adolescents.
- When cases open, 18 percent of the children are already living in out-of-home residential placements.
- Help in obtaining structured home-based services is not requested as often as family support advocates would wish. Requests for HFC's assistance in securing residential school placements increased 14 percent from 1987 to 1988.
- The needs of older adolescents in HFC cases differ from those of younger children.

HFC cases in which the client is defined as the family, including the caretaker and all children, indicate a need for a network of basic supports for families. For example, requests for help in paying for fuel and utilities increased from 1987 to 1988.

SHIFTING TOWARDS FAMILY SUPPORT

Should HFC redirect its advocacy and Interagency Team efforts away from crisis intervention and give greater priority to prevention and early intervention? Can HFC encourage the development of home-based alternatives to placement?

Priorities should be examined, but strong arguments exist against a wholesale redirection of Help for Children advocacy and the Interagency Team, including:

- It is unlikely that the children's services system will change rapidly to prevent crises and chronic problems. The need will remain for HFC to provide a safety net.
- The system, although more likely to intervene after problems emerge than to prevent them, is also not designed to routinely accommodate the kinds of cases seen by HFC. By resolving these cases, HFC generates changes in the system to benefit other children.
- Prevention and early intervention can be given more emphasis by HFC without abandoning children and families who have severe problems and may be difficult to serve. Information, referral and advocacy are important in helping families learn to use state and community resources to help themselves.

The Office for Children's task from a family support viewpoint is to maintain the safety net function of Help for Children while ensuring that all OFC programs are coordinated to promote a continuum of services for children, from prevention to residential care.

OFC operates several programs not discussed in this report. While HFC advocates on behalf of individual children and families, OFC's Community Development program works with local Councils for Children, volunteers who undertake "class" or "issue" advocacy on behalf of identified groups, such as pregnant teens or homeless families in their communities. The newly created Child Abuse Prevention Trust will mount a state-wide multi-media campaign to focus attention on the importance of the family as a social structure and eventually create a comprehensive family support network throughout Massachusetts. The Division of Licensing oversees the state's 13,000 licensed child care providers.

Together, these programs promote the full continuum of children's services. The Child Abuse Prevention Trust is a prevention program; Community Development and Councils are more likely than HFC to address prevention and early intervention issues. Promoting child care that families can afford, a Licensing Division project, is fundamental to strengthening the network of basic supports for families.

Help for Children plays a vital role in OFC's efforts to strengthen, balance and coordinate a continuum of children's services in Massachusetts. Through HFC, the Office can take additional steps to promote prevention, early intervention and home-based services. Key recommendations include the following actions:

- Selectively, but systematically, follow up information and referral calls to determine if additional help is needed to obtain prevention and early intervention services. Follow up, if documented, can also identify gaps in the service system's ability to meet these needs.
- Develop the Help for Children data system's capacity to identify gaps in prevention, early intervention and home-based services by revising HFC service categories to reflect family support issues and coding additional risk factors.
- Review program policies and identify other influences that affect the way HFC staff determine the types of cases targeted for intake.
- Consider asking for or requiring clinicians to answer the following question when advocacy for 24-hour residential placement is requested: What would enable or be necessary for this child to return home? The goal would be to encourage providers to plan for the child's return home and clinicians to consider home-based alternatives.²

² This concept is borrowed from the Department of Mental Health's proposal to ask similar questions of clinicians when they discharge children from the Gaebler Children's Center.

Not only Help for Children but also the larger child service delivery system must balance prevention, early intervention and advocacy for home-based services with crisis intervention and out-of-home placement. As a point of departure, the agencies that serve children should:

- Examine factors that seem to encourage the demand for residential placements. For example, the Department of Mental Health has defined its priority population as severely disturbed children. Does this definition shift its resources away from home- and community-based services to interventions such as intensive residential treatment facilities? Does the reimbursement formula for special education residential placements create a financial incentive for school districts to favor residential schools over arrangements which allow a child to progress educationally while living at home?
- Educate parents and teachers on the importance of identifying special needs early in their child's life and encourage parents to press for help early. Requests for HFC advocacy were three times more likely to involve children between the ages of five and 13 and three to five times more likely to involve children ages 14 to 17 years than children age four and under.
- Encourage private agencies to help families who do not quite fit eligibility criteria. For example, a family's heat is about to be shut off or they are about to be evicted, but their income is a few dollars over emergency assistance guidelines. If private agencies were to provide financial assistance and, for example, the Department of Public Welfare were to offer short term case management to avoid homelessness, they might prevent increased dependence on the state. The costs over the long term would be considerably less.
- Identify the choices agencies must make to manage increasing demands for services with limited resources. For example, are families going without counseling or homemaker services because the Department of Social Services must respond first to an increasing number of identified abuse and neglect cases? Do less severe mental health needs of children go untreated, perhaps becoming more severe, because the Department of Mental Health focuses on seriously mentally ill and severely emotionally disturbed children. How can state agencies better provide for older adolescents (18 to 22 years old) who are in special education programs but also need assistance to transition to adulthood?
- Instruct interagency working groups, including the Department of Education, to develop ways to shift service delivery toward prevention, early intervention and home-based services.

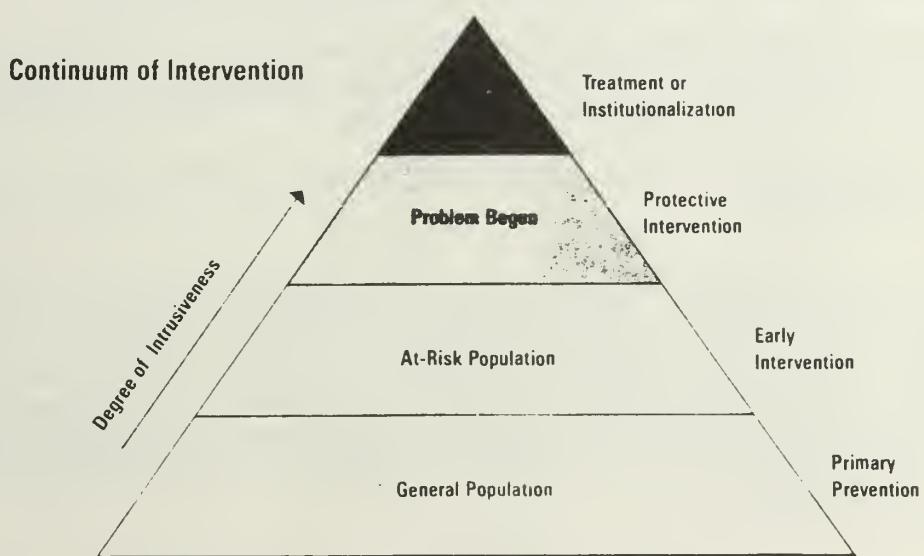
Broad philosophical agreement exists about the goals of prevention, early intervention and home-based services. Shifting funds and programs in this direction is particularly difficult when resources for children in crisis have decreased. However, even a modest redirection of programs would serve as a first step, and planning must begin if change is to occur in the foreseeable future.

THE FAMILY SUPPORT PYRAMID

Family support advocates call for three levels of service: increased attention to prevention; early, timely intervention for children at risk or experiencing problems; and home-based, rather than out-of-home, service delivery. Most family support advocates also acknowledge the need for a fourth level, out-of-home placement, but they argue that it should be infrequent and designed to return children home as quickly as possible.

These levels of service are often conceived of as a pyramid. One such pyramid, drawn to emphasize the need for widely available prevention services and very limited intrusion into the family is shown in Figure 1. As one moves up the pyramid, fewer children and families are served at a higher cost per child.

FIGURE 1: THE FAMILY SUPPORT PYRAMID*



*Reprinted by permission of the National Governor's Association from their publication America in Transition: Report of the Task Force on Children, Washington, D.C., 1989, page 4. Title added.

As used in this report, "family support" represents a broad philosophy of service that emphasizes prevention and home-based services. Among human service providers, the term sometimes refers to very intensive, short-term services targeted at families on the verge of moving into the top segment of the pyramid. They have a child who is about to be placed out of the home. The success of the intensive programs, along with other trends in children's services delivery such as "permanency planning" for children in foster care and the "deinstitutionalization" movement, have heightened interest in the broader philosophy.³

PREVENTION

The bottom level of the family support pyramid is made up of a broad network of community supports. These supports help families provide for the basics—shelter, food, and utilities. Child care, health care, and elementary and secondary education programs also fall into this first level. All are important in heading off problems.

AT RISK SERVICES

Next in the pyramid are services to families "at risk" or already experiencing "problems." Problems may involve one or more of the following: abuse or neglect, substance abuse, poverty and accompanying conditions like homelessness, a chronic illness or disability, a mental illness, teen parenthood, falling behind grade level, or dropping out of school.

When such factors are present, children may be at risk of: further abuse, neglect or other mistreatment; repeated crises and severe chronic medical or mental conditions; or failure to become adults capable of functioning independently in the community.

The boundaries between the levels of the pyramid are permeable. In addition, any specific service from financial help to medical care to family counseling can be important in preventing other problems for a child or family at risk.

Family support advocates promote home-based services to solve problems whenever possible, arguing that:

³ For a brief discussion of the climate now encouraging family support, see "Family-Centered Child Welfare Services: New Life for a Historic Idea" by Sandra M. Stehno in *Child Welfare*, May/June 1986. For a discussion of short-term intensive home-based "family preservation" programs and obstacles to reorienting the children's services system to family support, see Keeping Families Together: The Case for Family Preservation by Abigail Norman (New York: Edna McConnell Clark Foundation, 1985).

- Families are the best resource for caring for children. Even "multiproblem families" have strengths to build on.
- Services should be designed and delivered in a way that develops a family's capacity to help itself
- Out-of-home services should be avoided unless they are the only way to prevent harm to the child or solve the problem.
- If out-of-home services are necessary, community settings that are the least restrictive possible and that maintain family ties are preferable.

OUT-OF-HOME SERVICES

At the top of the pyramid are out-of-home services, including foster care, community residential programs, and institutions. These programs should be used to help children who cannot be cared for or protected at home. Included at the very tip are services to find children who cannot be reunited with their families other permanent homes.



HELP FOR CHILDREN OVERVIEW

The service levels of Help for Children (HFC)—information and referral, advocacy and team—parallel the levels of the family support pyramid.

INFORMATION AND REFERRAL

Information and referral (I&R) is considered a prevention service. It forms the base of the HFC family support pyramid, educating parents, children, and professionals who call. It provides advice and an entry way into the children's services system. I&R is available to any child or family in the Commonwealth. It is also the door to all other Help for Children services. A summary of I&R calls appears in Figure 2.

FIGURE 2: 1987 AND 1988 INFORMATION AND REFERRAL REQUESTS

Service Category	1987	1988
Child Care	38,560	25,855
Special Education	7,503	7,351
Basic Needs	4,390	4,583
Placement	4,228	4,022
Camps and Recreation	2,711	2,493
Potential Providers*	2,592	3,974
Mental Health/Retardation	2,493	2,289
Health Care	2,103	1,581
Legal Issues	1,531	1,354
Abuse and Neglect	1,305	1,551
General Education	1,171	1,309
Other**	11,290	12,337
TOTAL	79,877	68,699

* For example, people who would like to become foster or adoptive parents.

** Includes referrals to hotlines, specialized I&R services, and state agencies as well as questions about child development, parenting, and injury prevention.

HFC responded to 79,877 requests for information in 1987 and 68,699 requests in 1988. The large majority of requests were for child care information: 38,560 requests in 1987 and 25,855 requests in 1988. Over the past two years, OFC has created a network of Child Care Resource and Referral (CCR&R) agencies to provide Massachusetts parents with comprehensive child care information and referral services. HFC now refers all but certain specialized child care requests to CCR&Rs. As these agencies become better known, it can be expected that more parents will call the CCR&R, and not HFC, first.

ADVOCACY

Advocacy is the next level of service. This level primarily targets children and families who are at risk or experiencing problems. It is needed when information and referral is not enough to support the family. For more than 90 percent of the child advocacy cases in 1987 and 1988, one or more "risk factors" are recorded. Help is sought after the family is in crisis. In addition, families are likely to be in conflict with the agency responsible for serving them. In some cases, no agency is responsible for providing the needed services.

Help for Children responded to 7,325 advocacy requests in 1987 and 6,289 requests in 1988. A breakdown of the advocacy requests by service category for 1987 and 1988 is shown in Figure 3.

FIGURE 3: 1987 AND 1988 ADVOCACY REQUESTS

Service Category	Number of Cases	
	1987	1988
Special Education	3170	2777
Placement*	1095	934
Basic Needs	797	802
Case Management	610	550
Recreation	560	422
Health Care	187	131
Mental Health & Retardation	210	127
Child Care	149	120
Transportation	169	109
General Education	106	106
Financial Assistance	133	104
Legal Assistance	111	86
Homemaker Services	18	15
Employment	10	5
TOTAL	7325	6288

* As defined by HFC for routine reporting purposes. Includes some specific services like respite care that are not included in the family support definition of "out-of-home placement" discussed in this report.

The caseload decreased by 14 percent from 1987 to 1988 while the complexity and severity of problems increased. Cases for children with more than one disability increased from 25 percent in 1987 to 35 percent in 1988. Requests for group homes and residential schools, one type of placement request that may require unusual amounts of time and signal severe child and family problems, was the specific service requested second most frequently each year. Although requests for placement services overall decreased, requests for group homes and residential schools increased 14 percent.

The percent of requests made directly by parents or guardians increased from 69.2 in 1987 to 73.6 in 1988, while the number of requests from professionals calling on a family's behalf decreased. Professionals referred 571 fewer advocacy requests, half of the total decrease in cases.

Over 40 percent of the advocacy caseload involves helping families obtain special education services through local public schools, a critical service for at risk children. Advocates explain the special education system to parents and teach them how to represent themselves. If necessary, advocates accompany parents to meetings and present arguments on the child's behalf, or help iron out problems between the school and the parents.

Parents most frequently call HFC to ask for help with core evaluations, the entry point for special education services and the mechanism for determining the type of service to be provided. Some parents need help in resolving disagreements with schools about changing the type or extent of services provided. Others need guidance through the elaborate mediation and appeals processes provided by the state's special education law, Chapter 766.

Help for Children staff also assist some of the most troubled and difficult to serve children in obtaining the services they need from public and private human service agencies. These agencies may be a complicated maze to the uninitiated, with overlapping and confusing mandates and policies about who they serve and how.

Both the human service and special education cases HFC takes on often involve children with severe or multiple disabilities. Many have a history of personal and family problems. Two-thirds of advocacy requests involve boys; one-third involve girls. Children tend to be older with problems that have been overlooked or inadequately addressed at younger ages. In 1988, 33 percent of HFC's advocacy cases involved 14 to 17 year olds. Almost 27 percent involved 10 to 13 year olds.

Breakdowns of advocacy cases for 1987 and 1988 by age group and the five disabilities most frequently named as the "primary impairment" related to the service request are shown in Figures 4 and 5. The caseload reflects the age at which impairments are likely to be diagnosed. Developmental disabilities, for example, figure more prominently in cases involving younger children; learning disabilities in the school age population. In addition, the caseload is influenced by the age at which children with particular disabilities face difficulties finding the services they need.

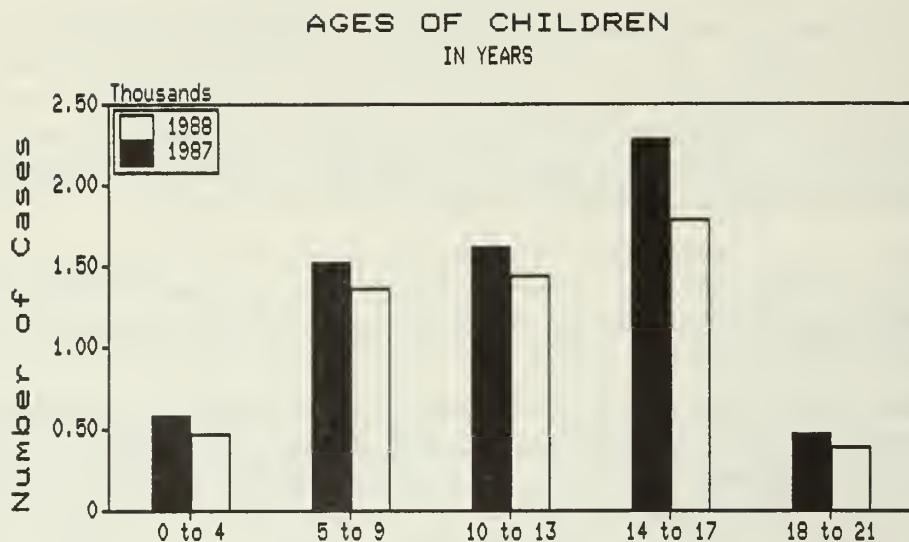


Figure 4

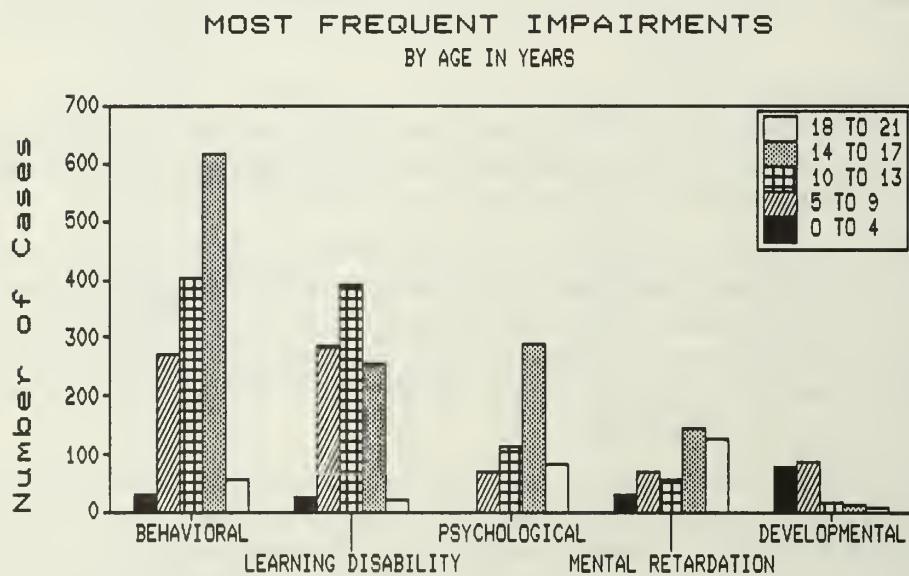


Figure 5

In many cases, several state or private human service agencies or one or more of these agencies together with the local school system share responsibility for helping these children. Sometimes, no one is coordinating an interagency response or each believes

that the others should bear full responsibility. Some children require intensive, unusual or costly services. Programs may not exist or be full. Families may need emergency services but fail to meet eligibility criteria. Some have used up available benefits. When children and families "fall through the cracks" because of conflicting agency policies or unusual needs, Help for Children provides a safety net.

Thus HFC gives priority to children at risk or experiencing problems. Some advocacy cases, however, involve children with no identified risk factors; a number involve requests for out-of-home placement. More than 80 percent of the total advocacy caseload involves children under 18. These cases can be divided into three groups:

- (1) Children for whom no risk factors were coded.⁴ In these cases:
 - Children tend to be younger than the group with coded risk factors.
 - Requests are disproportionately for prevention services, including child care, camps and recreation, basic needs and general education compared to cases involving children with risk factors identified.
 - Special education core evaluation is the most frequently requested service, the same as for children with risk factors identified.
- (2) Children with the following risk factors coded:
 - Disabilities—75 percent of the cases involve children with at least one disability.
 - Court Involvement—11 percent indicate some type of court involvement.
 - Parental abuse and neglect—about nine percent involved children with abusive parents.
 - Running away, pregnancy or adoption—a small percent identify these issues.
- (3) Children for whom an out-of-home residential placement, as defined later in this report, was requested.

Figure 6 summarizes requests for services for children under age 18 divided into these three groups:

⁴ Risk may, nevertheless, exist. The system does not, for example, record poverty indicators, parental substance abuse, or long term parental illness. This report includes a recommendation that HFC begin to code additional risk factors.

FIGURE 6: ADVOCACY CASES FOR CHILDREN 0 THRU 17 YEARS OLD

CATEGORY	1987	1988
	Number (%)*	Number (%)*
No Risk Factors Coded	569 (7.8)	466 (7.4)
Risk Factors Coded	4516 (61.7)	3790 (60.3)
Out-of-Home Services	902 (12.3)	784 (12.5)
TOTAL CASES TO AGE 18	5977 (81.8)	5040 (80.2)

* Percents represent the proportion of the total caseload, including families and older adolescents, in each category.

The cases in these three categories decreased at different rates. Cases with no coded risk decreased the most (18 percent), at risk cases next (16 percent) and out-of-home residential services somewhat less (13 percent). The differences suggest increasing demand for and priority given to not only at risk but also out-of-home services.

While Help for Children must not reduce efforts to help children obtain necessary at risk and out-of-home services, the program must determine whether additional energies can be focused on prevention and early intervention.

THE INTERAGENCY TEAM

The Interdepartmental Children's Service Team, usually called the "Interagency Team" or "Team," sits at the tip of the Help for Children family support pyramid. When HFC advocates cannot resolve a case at the local level, they refer cases to the Interagency Team serving their region. These teams are composed of representatives from the regional offices of state agencies which serve children. The regional team decides which agency should take responsibility for case management and funding. Cases that cannot be resolved regionally are "escalated" to the Central Team and, if necessary, to the Executive Office of Human Services (EOHS) for resolution.

In 1987, the Central Team acted on 62 cases; in 1988, on 46 cases. Six cases in 1987 and three in 1988 were further escalated to EOHS for resolution. Figure 7 details impairment categories for children in 1987 and 1988 Central Team cases. In over 90 percent of cases escalated to the Central Team, the child needed out-of-home residential placement.

IMPAIRMENTS IN CENTRAL TEAM CASES

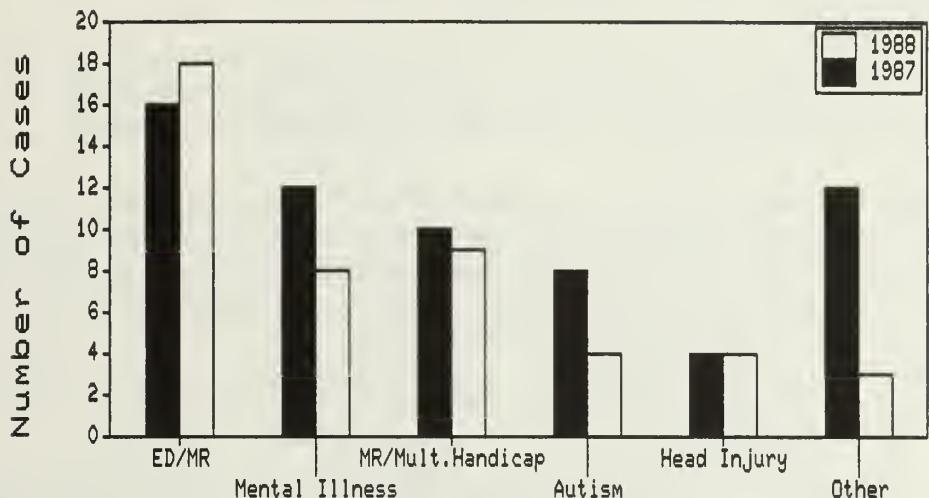


Figure 7

A very high percentage of Central Team cases—the majority in 1988—involved children with mental retardation, ranging from moderate to severe, combined with at least one other impairment. The most common combination was mental retardation and emotional/behavioral disorder, appearing in 25 percent of the 1987 and 35 percent of the 1988 cases. Compared to the general advocacy caseload, the percent of Team cases for medically involved, multiply handicapped children with mental retardation was extremely high.

Central Team cases, although small in numbers, illustrate policy and program gaps in the service delivery system. They demonstrate the important role of clear policies in defining an agency's responsibilities for children. They also show the need for resources to implement these policies.

TOM

Tom suffered a severe head injury at eight years of age. At 16, after a series of psychiatric hospitalizations, he was admitted to an intensive residential treatment program for the mentally ill. The program kept him on even though his needs differed from those of their other clients. Tom needed a program designed for the head injured. There are no programs licensed in Massachusetts that are specifically designed to serve adolescents with severe head injuries.

At 18, Tom's case came to Team. The Department of Education would not approve special education funding to enroll Tom in a specialized program outside of the state. Team assigned temporary responsibility to the Massachusetts Rehabilitation Commission's

Statewide Head Injury Program (SHIP), pending a hearing before the Bureau of Special Education Appeals. The hearing officer determined that special education funding should be approved and also recommended that an in state program be developed.

Tom will soon need a long-term structured setting. When he celebrates his twenty-second birthday, his special education entitlements will end and the Statewide Head Injury Program will be responsible.

Although small in numbers, head injured youth referred to Team were the most difficult to place. The stumbling block was an interagency dispute between school districts and SHIP. Each considered the other responsible for rehabilitative services. This dispute was compounded by the lack of an appropriate in-state program. Children had to go to other states at a cost of about \$150,000 annually per child.

Other examples of policy and program gaps addressed by Team or reflected in the Team caseload for 1987 and 1988 are:

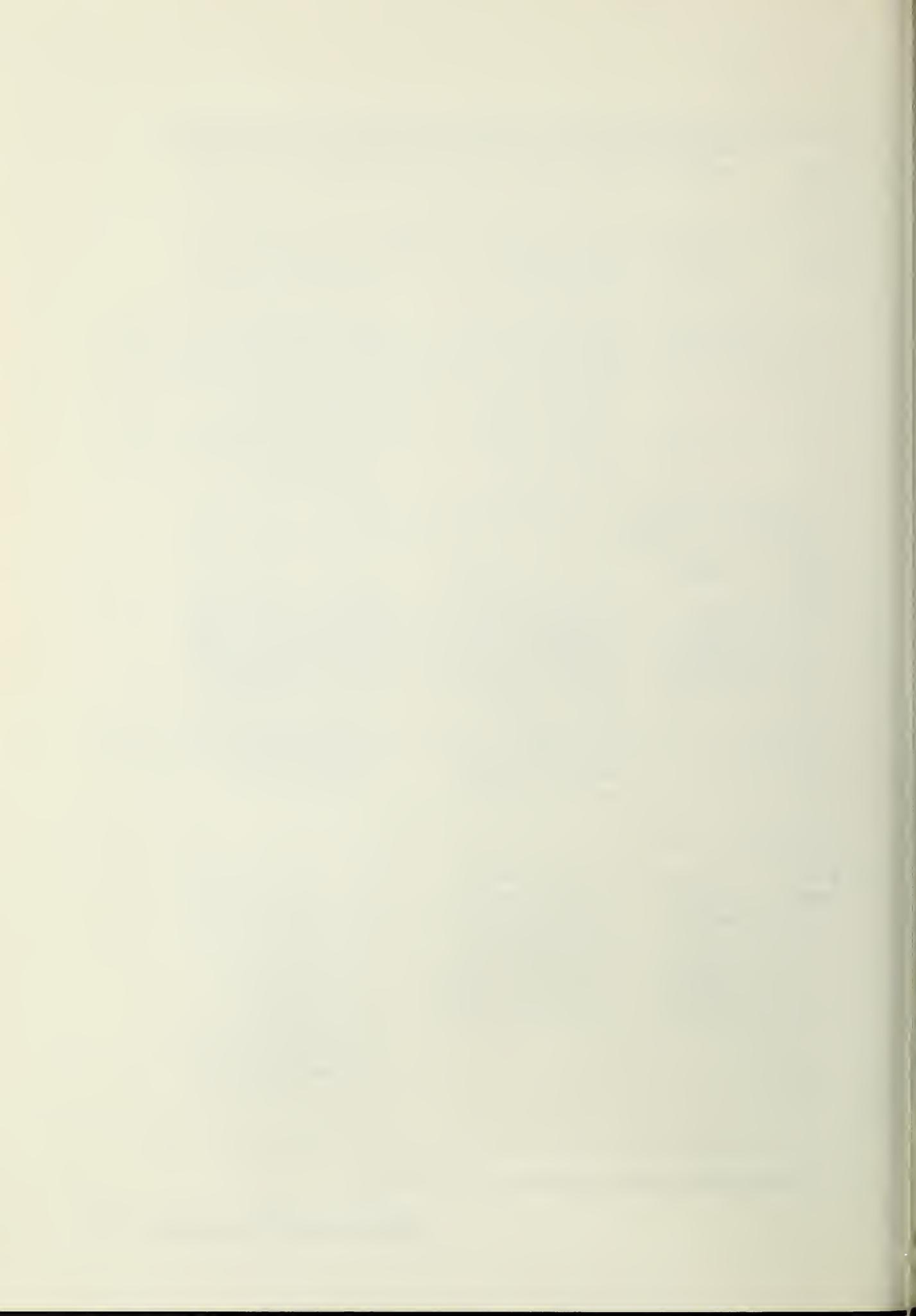
- Responsibility for 24 hour residential programs with an intensive therapeutic component for children with mental illness when parental abuse or other family problems that fall under the Department of Social Services' mandate exist.
- Responsibility and resources for children with both mental retardation and emotional/behavioral disorders. Responsibility was not clearly defined when the Department of Mental Retardation split from the Department of Mental Health. The issue is complicated because resources for residential placements are lacking.

Figure 8 provides a summary description of Help for Children information and referral, advocacy and the Central Team.

FIGURE 8: HELP FOR CHILDREN SERVICES BY FAMILY SUPPORT LEVEL

Family Support	Service*	Description	Example
Out-of-home	Central Team 54 cases per year	Cases cannot be resolved by local action or by regional interagency teams. Reviews policy issues and disagreements between agencies about who is responsible for services. Identifies ways to bridge resource gaps.	Dawn is a client of two state agencies. She has a mental illness and was sexually abused at home. She needs structured residential care. Each agency is arguing that the other should be responsible. Team has been asked to decide who should fund the placement.
At risk services	Advocacy 6,800 cases per year	I&R is not enough to support the family. Families may be in conflict with a state agency or school system. Sometimes no agency is clearly responsible. Most children have at least one disability or other problem.	Ray is 11 years old. He is two years below grade level and is not progressing in his local school's resource room for learning disabled children. His parents need help appealing the school's decision not to provide any additional services.
Prevention	Information and Referral 74,300 questions per year	Serves as the entry to HFC. Directs families to resources and provides information to help them learn how to advocate for their own needs.	Mrs. D. wants to know how to find a special needs camp that could provide a scholarship for her son. A social worker is helping a family whose gas is to be shut off. They do not qualify for the programs she knows about. Are there other resources?

* Average number of cases or questions for 1987 and 1988.



PREVENTION AND EARLY INTERVENTION

This section discusses two prevention and early intervention issues that emerged from the Help for Children caseload. Family cases, which indicate a need for programs to help families provide for their children's basic health and welfare, are described first. Then cases involving learning disabilities and emotional/behavioral disorders are discussed, highlighting the importance of identifying learning disabilities early in a child's life.

FAMILY CASES: DEVELOPING NETWORKS OF BASIC SUPPORTS

BACKGROUND

It's Never Too Soon: A Blueprint for Preventing Child Abuse by Strengthening Massachusetts Families⁵ argues that a combination of strategies is needed to strengthen families and reduce the multiple stresses that contribute to child abuse. One strategy involves strengthening programs to help families satisfy their basic needs for shelter, heat, and food. These programs would also help families obtain health care and child care, as well as an education for their children. This network of federal, state, and community programs would not only help families provide for their children, it would also protect children.

Traditionally, Massachusetts has done a good job of investing in supportive programs that help families provide for the health and well-being of children. Massachusetts was the first state to supplement federal funds for the Special Supplemental Food Program for Women, Infants and Children (WIC). Aid to Families with Dependent Children (AFDC) benefits are among the highest in the country.

Benefits have not kept pace, however, with the cost of raising a family in Massachusetts. Housing, in particular, has taken a large bite from family income. In Massachusetts, the 1974 median rent for the lowest income class represented 35 percent of the family's

⁵ Report of the Massachusetts Special Legislative Commission on Violence Against Children and Executive Office of Human Services. March 1988.

income; by 1983, it was 45 percent and, by 1986, it was as high as 85 percent in some parts of the state.⁶

Help for Children cases in which the client is defined as the family unit including the caretaker and all or several children, as opposed to an individual child, reflect this growing need for basic supports. The number of family cases increased as a percent of the total caseload, from 11.8 in 1987 to 13.5 in 1988. The number of cases decreased only slightly from 866 cases in 1987 to 852 in 1988.

Family cases usually involve requests for help in obtaining fuel and utilities, housing, and food. These and other requests for clothing and moving expenses are categorized in the HFC data system as "basic needs", and total 81 percent of the family cases in 1987 and 85 percent in 1988. Families also requested case management, financial assistance, health care, transportation, child care, and homemaker services.

HFC advocacy on behalf of these families is limited almost exclusively to instances in which the family is in crisis *and*, because of eligibility restrictions or the unusual nature of the situation, no state agency will assume responsibility. In half of the 1987 cases and three-fourths of the 1988 cases, families did not fit federal, state or agency eligibility criteria, or no agency was defined as responsible for their problem. For example, some families were a few dollars over the income guidelines for Department of Public Welfare (DPW) or federal assistance programs. Some had used up emergency fuel assistance benefits.

Some families represent a lower priority for agency services. For instance, because abuse or neglect has not occurred in a family, it may be difficult to obtain services from the Department of Social Services. Funding has not kept up with the significant increase in cases that involve child abuse and neglect, DSS' priority for service.

HELP FOR CHILDREN BASIC NEEDS REQUESTS FOR FAMILIES

Figure 9 shows changes in the most requested services within Help for Children's basic needs category for 1987 and 1988.

Fuel and utilities outstripped other types of basic needs requests and accounted for the proportional increase in family cases in 1988. Typically, these requests related to heating bills. Utility requests rose from 40 percent of all family cases in 1987 to 50 percent in 1988.⁷

Increases in the cost of living without corresponding increases in wages or assistance programs leave families without enough to keep their children housed, fed and warm. HFC utility requests signal that money is running out before families pay all their bills.

6 Philip W. Johnston, Nancy K. Kaufman and Amy A. Anthony, "The Massachusetts Approach to Homelessness" in Homelessness: Critical Issues for Policy and Practice (Boston: The Boston Foundation, 1987)

7 The number of fuel assistance cases in the Department of Public Welfare's Emergency Assistance Program rose from 1,207 in 1987 to 1,483 in 1988.

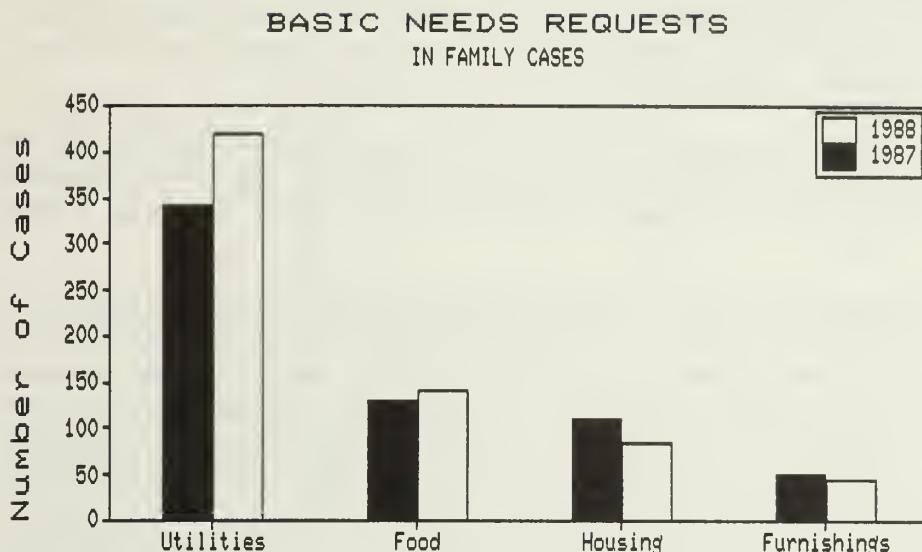


Figure 9

FLEXIBLE RESOURCES — CASE MANAGEMENT AND FINANCIAL ASSISTANCE IN HELP FOR CHILDREN

Family cases highlight a need for flexibility within the system that will allow it to provide help in crises and emergency situations that affect all family members. A small amount of money, for example, may tide a family over, averting a fuel shut off or eviction that would in turn create multiple problems. Meanwhile, the family can locate more stable resources.

The flexible resources offered to families by Help for Children include case management and financial assistance. For this reason, the Office for Children was most frequently, and increasingly in 1988, the primary agency providing these services for families represented in the HFC case load. It was the primary provider in 44 percent of the 1987 cases and 59 percent of the 1988 cases. Private agencies were the other major provider, serving as primary provider in 27 percent of the 1987 and 19 percent of the 1988 cases.

In both 1987 and 1988, 38 families requested case management. Providing case management helps families organize their search for basic support services available through public and private agencies. (Some case management is coded under these service categories instead of being coded as case management.) HFC advocates help because families do not meet the service criteria of agencies, like DPW and DSS, that provide case management.

In limited circumstances, Help for Children offers direct financial assistance through its "individual kid money" (IKM) fund. From 1987 to 1988, advocacy cases for basic needs, including a small percent of child cases, increased by about one percent. Requests for

IKM to pay for basic needs increased by 42 percent. The total funds allocated by the Legislature for IKM remained constant at \$190,000 each year. After HFC staff documented the need and lack of other resources, 90 percent of these requests were approved, an approval rate only six percent lower than the previous year's.

Help for Children family cases point to the need for investment in basic supports like low income housing development. Outreach to encourage families to use existing services (such as food stamps), that stretch family income and help prevent emergencies, is also important.

Help for Children data and experience suggest hypotheses on who is affected by gaps in the network of basic family supports, how families end up in crisis, and why they are missed by federal, state and private programs. The decrease in private agency providers in Help for Children family cases, for example, suggests cuts (or funding levels that do not keep pace with rising costs) not only in federal but also in private funds for basic needs assistance. Comparison of data collected by various agencies and other research is needed to determine what services are lacking and how to develop effective ways to support families.

LEARNING DISABILITIES AND EMOTIONAL/BEHAVIORAL DISORDERS

Identifying children with specific learning disabilities early is critical in preventing future problems. Educational failure makes a productive adult life difficult.

Learning disabilities and emotional/behavioral disorders are the two most frequently identified impairments in the advocacy caseload. They are also the most frequently paired disorders, with one listed as the primary impairment and the other secondary.

Learning disabilities include perceptual, memory, attention, orientation, and other disorders in using spoken and written language. Excluded are disorders that are the result of mental retardation, mental illness, vision or hearing loss, or environmental disadvantages. Emotional/behavioral disorders, as defined by Help for Children, include a broad range of nonspecific disorders but exclude psychiatric diagnoses like paranoia, manic depression, and schizophrenia.

From 1987 to 1988, learning disability increased slightly as a primary impairment and decreased slightly as a secondary impairment. Cases involving emotional/behavioral disorders decreased as a primary and increased as a secondary impairment. Figure 10 illustrates the number of cases in 1987 and 1988 with each impairment.

Almost 30 percent of cases that list learning disabilities also involve emotional/behavioral disorders. The number of cases listing both impairments remained virtually the same, about 385 cases, with a shift toward learning disability as primary.

FIGURE 10: CASES WITH LEARNING DISABILITIES AND EMOTIONAL/BEHAVIORAL DISORDERS

	1987	1988
Learning Disabilities		
Primary	970	981
Secondary	380	354
Total Cases	1350	1335
Emotional/Behavioral Disorders		
Primary	1717	1373
Secondary	511	566
Total Cases	2228	1939

Help for Children casework suggests that school failure due to unaddressed learning disabilities may contribute to other problems including truancy, depression, and contrary or "oppositional" behaviors that would be coded as "emotional/behavioral disorders." One such cases is described below:

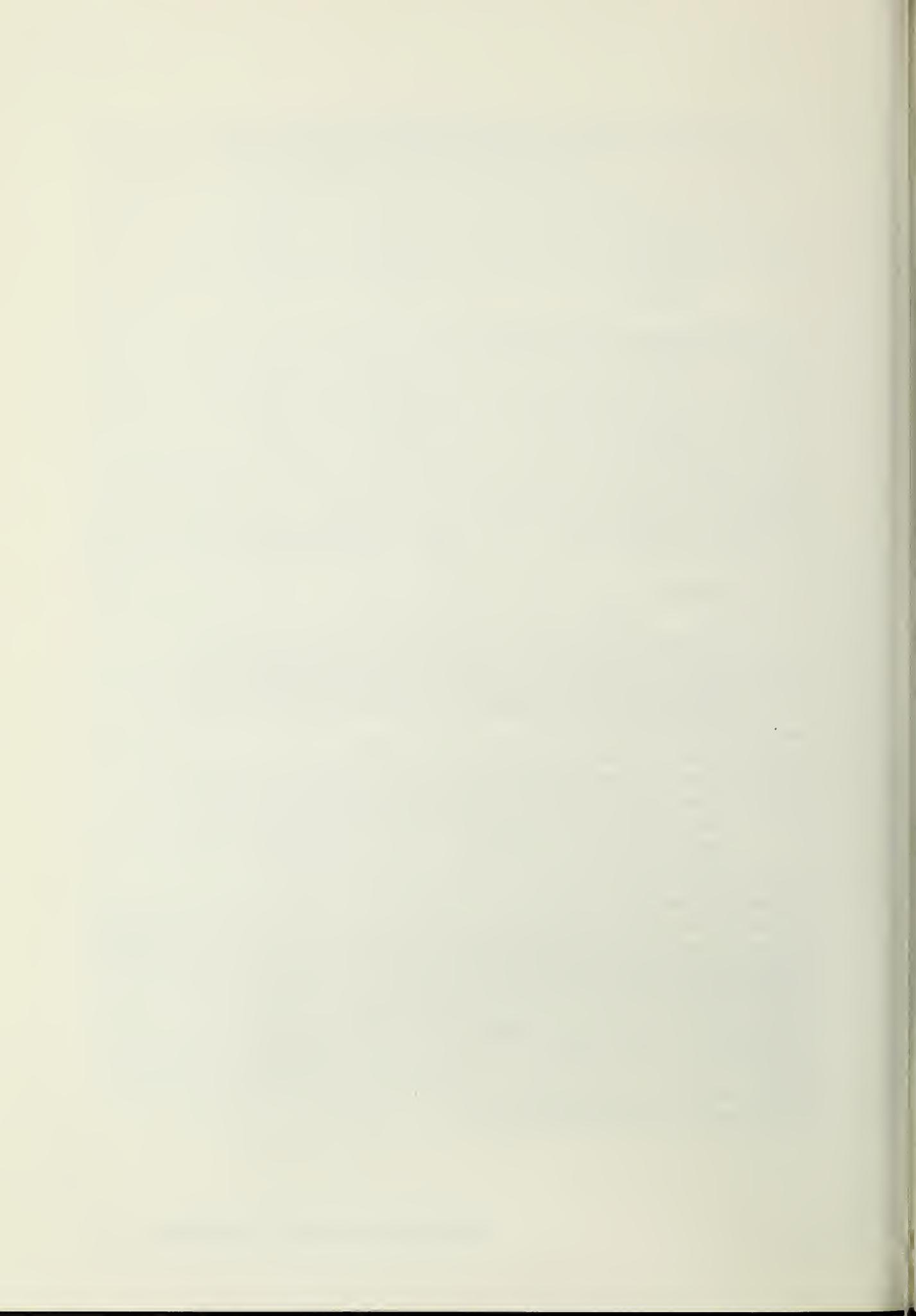
GEORGE

George was 14 years old, in middle school, and failing most of his major academic subjects. After fourth grade, when his achievement test scores were good, he stopped making any progress. He was becoming depressed, beginning to skip school, and falling behind his age group in social skills.

George was language disabled. After intervention by his parents, an advocate, the school's special education administrator, and a mediator, he began attending a private day school whose speciality was teaching learning and language disabled children. Now his self-esteem is improving, he is learning and enjoying school.

A high percent of the learning disabled children in the HFC advocacy caseload are between the ages of 11 and 14 years. Many learning disabilities can be identified by alert parents during a child's preschool years. Others only become apparent when the child is asked to perform school tasks that are difficult given the particular disability.

To help parents learn to identify learning disabilities while their children are still young, several Help for Children advocates have designed and run community education workshops in conjunction with OFC's Community Development Program. These efforts should continue. The earlier disabilities are identified, the sooner the learning program can be adjusted, averting other difficulties.



HOME-BASED VS. RESIDENTIAL SERVICES

Help for Children receives a significant number of requests for out-of-home residential placements. After clarifying the definition of "out-of-home residential placement" used in this report, this section probes the meaning of these requests. It first describes changes in the residence of children served and the characteristics of their placement requests, particularly requests for residential schools. The data document a high demand for residential placement services. Several family support issues are then raised, including a suggestion that the high demand for residential placements may obscure an underlying need for home-based and less restrictive services.

DEFINITIONS

The following services, grouped by level of restrictiveness, plus adoption and residential placement transportation, are considered "out-of-home" for purposes of this report:

Less Restrictive

- Community residences/halfway houses
- Supervised apartments
- Special education 502.6 prototype (school district approval of a residential school placement)
- Group homes/residential schools

More Restrictive

- Department of Mental Health residential treatment programs
- Psychiatric hospitals
- Residential drug and alcohol treatment facilities

Most Restrictive

- Intermediate care facilities
- Pediatric nursing homes
- Department of Mental Health intensive residential treatment centers
- Department of Youth Services secure treatment

Of all HFC out-of-home advocacy cases, 75 percent involve requests to place children in residential schools, group homes, or related 502.6 prototypes.

HFC also receives requests for foster care and specialized foster care, services that are usually considered out-of-home placement. These requests each account for only about one percent of the total advocacy caseload. Help for Children clients who request assistance in securing foster care services tend to seek foster care as an alternative to a residential placement. To focus on residential placement issues, foster care and specialized foster care are not included in this report's definition of out-of-home placement.

RESIDENCE OF CHILDREN

Help for Children records the custody and residence of children when cases are opened and closed. This data help put family support concerns about Help for Children placement requests in context.⁸

More than 90 percent of the children who are living at home when a case opens are still there at case closing. More than 90 percent of children who were in the custody of their parents are still in parental custody when their cases are closed. These data indicate that Help for Children advocacy itself supports keeping children with their families.⁹

More surprising is that one-quarter of the children represented by these cases are not living at home, either when cases open or when they close. In 1988:

- When cases were opened, nearly 18 percent of these children were already in out-of-home residential settings as defined by this study.
- An additional four percent were in foster care at intake and five percent were living with relatives or friends or in other types of placements.

HFC serves a disproportionate number of children in placement. As of 1982, only one percent of the nation's children under 18 lived with foster parents, other non-relatives, or in "institutions." Two percent lived with grandparents or other relatives; the remainder with biological, step and adoptive parents.¹⁰

8 The custody and residence section discusses cases closed in 1988; 1987 figures are similar. Discussion is limited to closed cases because only closed cases code changes in custody and residence.

9 Most advocacy is not, however, specifically to keep children at home. Special education, for example, is to promote learning not to prevent placement. although it may indirectly affect whether a child remains at home.

10 Estimate reported by James K. Whittaker, "Family Support and Group Child Care: Rethinking Resources" in Permanence and Family Support: Changing Practice in Group Child Care, Gary O. Carman and Richard W. Small, editors. (Washington, D.C.: Child Welfare League of America, 1988)

Many children who were in residential placements when Help for Children cases closed, were already there when cases opened. Those who moved from psychiatric hospitals to residential schools were almost equal in number to those moving from home to residential schools. In 1988, of 513 children in residential schools or group homes when cases closed:

- 160 (31 percent) were already in these placements when cases opened.
- 154 (30 percent) moved there from home.
- 147 (29 percent) moved there from other more restrictive settings, in the large majority of cases, psychiatric hospitals.

Of the 234 children in psychiatric hospitals, other mental health placements or other restrictive settings:

- 144 (62 percent) were there initially.
- 61 (26 percent) moved from home.

Of the 197 children in foster care at closing:

- 122 (62 percent) were there at intake.
- 32 (16 percent) moved from residential placements to these home settings, primarily from psychiatric placements.
- 29 (15 percent) moved from home.

HFC data document the existence of a path out of more restrictive mental health settings to less restrictive residential schools, group homes, and foster care. In addition to the information presented above, of the 2,801 children at home when cases closed, 152 children (five percent) moved there from psychiatric and other restrictive settings and 28 (one percent) from residential schools.

Family support advocates would argue, however, that this movement out of residential settings should be accelerated. More children should be moving home, particularly from psychiatric hospitals. Family support advocates also would be concerned that the number of children who moved from their homes to residential settings was nearly equal to the number who moved back home.

RESIDENTIAL PLACEMENT REQUESTS FOR CHILDREN UNDER 18

OVERVIEW OF REQUESTS

The number of HFC advocacy cases involving residential placements for children under 18 years of age decreased by 13 percent from 1987 to 1988. In both years, requests were predominantly for adolescents, most of whom had emotional/behavioral disorders.

Figure 11 gives HFC statistics for out-of-home placements requested for this age group by the type of placement sought.

FIGURE 11: PLACEMENT REQUESTS FOR 0 TO 18 YEAR OLDS

TYPE OF PLACEMENT	1987	1988
Residential School/Group Home	376	430
Chapter 766 502.6 Prototype	290	191
DMH Residential Treatment	72	28
Psychiatric Hospital	66	55
Residential Drug/Alcohol	33	18
DMH Community Residence	13	16
Intensive Residential Treatment	9	16
Other*	43	30
TOTAL	902	784

*Includes less than ten requests per year for each of several minor out-of-home service categories, with the decrease spread across categories.

RESIDENTIAL SCHOOLS

Demand for residential schools¹¹ appears to be increasing, with HFC advocacy services less necessary if full Chapter 766 funding of the program (a 502.6 prototype) can be justified.

- Help for Children residential school/group home requests increased by 14 percent.
- The Department of Education reported that the 502.6 prototypes increased by 69 percent statewide from October of 1986 to October of 1988. HFC cases in this category decreased by 34 percent from 1987 to 1988.

The increasing demand for residential schools is of concern to family support advocates. The reasons for this increase should be explored. Some reasons are suggested in the following pages.

FAMILY SUPPORT ISSUES

HOME-BASED SERVICES TO PREVENT PLACEMENT

Some Help for Children case histories suggest that home-based services might be more appropriate for children or that home-based services might have prevented placement:

¹¹ The Help for Children data system combines residential school and group home requests in one category. Data about residence of the child at closing indicates that the service provided in most cases is a residential school. See "Less Restrictive Community Based Alternatives" in the next section for discussion.

JIMMY

When Jimmy came to Team, he was 20 years old. His behavioral problems had become so severe that only one residential school — located in Texas — would accept him.

From three years of age, Jimmy suffered up to 100 uncontrollable petit and grand mal epileptic seizures a month. Neurological damage caused by the seizures resulted in Jimmy's bizarre and socially unacceptable behavior. Until he turned 12, teachers in Jimmy's special education classrooms were able to manage him. After that, he was moved from one educational setting to another, each lasting about six months.

Jimmy's parents tried to keep him at home but could not. He lived in a series of foster homes, but ran back home repeatedly.

Had a consistent, coordinated program featuring in-home behavioral training, case management, and regular respite care been available to Jimmy and his parents when Jimmy was young, placement outside his home might have been avoided. Early intervention might have extinguished his problem behaviors before they became entrenched.

Cases like Jimmy's should be systematically documented. From a family support perspective, it is unfortunate that the Help for Children database cannot help us estimate the percent of residential placements that could have been avoided.

Intensive home-based services as an alternative to placement are very limited in Massachusetts. The Department of Mental Health funds one such intensive mental program in Boston. A 1988 paper reported that seven private, home-based family centered programs existed that provided "family preservation" services designed to prevent placement, particularly for dysfunctional families with children who have been abused or neglected.¹²

On the positive side, several state agencies are discussing ways to develop home-based services. Case managers in state agencies also attempt to develop service plans, using contracts with vendors and community supports, to provide services in the home. The Department of Mental Retardation, in particular, has emphasized such service planning. Often, however, more is needed to prevent placement.

The lack of home-based mental health programs leaves parents of troubled teens with few alternatives. The number of ten to 19 year old Americans discharged from psychiatric units increased 43 percent from 1980 to 1987, while the population in this age group shrank 11 percent.¹³ Good home-based programs designed to treat specific emotional or behavioral problems could replace costly, perhaps unnecessary, in-patient psychiatric treatment for many adolescents.

¹² "Family Preservation Services" by Cherilyn E. Davidson. Unpublished paper for Child Study course at Tufts University, Boston, Massachusetts.

¹³ "Children's Wards: Teen-agers End Up in Psychiatric Hospitals in Alarming Numbers," Wall Street Journal, 2/3/89, page 1.

HOME-BASED "AFTERCARE"

Of equal importance is where children go after treatment in restrictive settings, such as psychiatric hospitals. Family support advocates believe that many children in psychiatric hospitals stay longer than necessary or go to residential schools because home-based services or less restrictive community mental health programs that could provide structured aftercare do not exist. Help for Children data on the number of children going from restrictive placements to residential schools support this view.

Professionals who want to move children out of restrictive settings have few alternatives to residential schools and group homes for children who need more structure or support than parents alone can provide. Clinicians in institutional settings may not be inclined to view a home-based program as a reasonable alternative; and tend to specify aftercare in a structured residential placement in assessments when they discharge a child. These clinical decisions create a demand for residential services, but may not reflect the least restrictive possible approach. Programs that provide structured in-home supports may address the child's need more effectively.

JEFF

Although only three years old, Jeff was discharged after his second inpatient evaluation in a year with a recommendation for a residential placement. His medical and behavioral problems required constant active supervision and appeared too much for any family.

Jeff was diagnosed with pervasive developmental disorder with autistic features and a seizure disorder. He was self-abusive, scratching his face and pulling his hair. He chewed on electric cords and climbed on furniture without apparent regard for his own safety.

Jeff's parents were fully committed to caring for him, but they were overwhelmed. His mother had a mental illness; his father, an alcoholic, had been sober for a year and had just returned to work.

After his discharge from the hospital, Jeff was sent to a respite facility. He was well cared for, but there was no educational program. His case was referred to a regional interagency team for help in finding an agency to take responsibility for a providing a program with an educational component.

In the meantime, an extraordinary family who wanted to care for a child with severe disabilities was identified. After initially questioning whether any family could care adequately for their child, the parents agreed to allow the family to provide specialized foster care.

Now Jeff attends a special needs day school near his foster home. The biological parents, the foster parents, and the school get professional support from a residential facility's contracted family support program. Jeff returns to his biological family for short visits, and the parents check in regularly with the foster family. Through the foster parents and professional support, the biological parents are learning how to take care of Jeff.

In most cases as severe as this one, specialized foster care, the day school and professional supports to the parents and foster parents would have cost about the same as a residential placement; in this case, specialized foster care also saved the state about \$12,000 a year. Most important, in spite of Jeff's disorder and his parents' problems, he can grow up in a home setting and develop strong positive relationships with both his foster and biological parents.

LEAST RESTRICTIVE COMMUNITY BASED ALTERNATIVES

When placement is necessary, the family support philosophy calls for seeking out the least restrictive appropriate placement located closest to the child's home. Included among the desired options would be community mental health programs and group homes. In Massachusetts, these resources are not sufficient to meet the need.¹⁴

Group homes tend to be closer to the child's community than residential schools. They are less restrictive because children may attend day school programs with children who do not live in the group home.

Because Help for Children combines residential schools and group homes in one service request category, the data system may obscure a need for group homes. When cases close, most children in the caseload are living in residential schools, not group homes.

School districts, like human service agencies, respond to clinical assessments that call for 24 hour residential placement. They also receive less financial assistance from the state for non-residential special education services which, when transportation is included, may cost as much as a 502.6 residential school placement.

From both family support and fiscal standpoints, these issues should be examined further. Financing and other issues that influence, and possibly impede, the development of community based mental health programs should also be examined.

CUSTODY

The large number of requests for placement in residential schools and group homes is also important because this type of placement raises custody issues. The family support philosophy is based on helping parents develop their ability to make and carry through on decisions that affect their children's lives. In addition, family support is also geared toward strengthening the parents' ability to develop and maintain strong personal relationships with their children. Custody is critical to these ends.

More than 90 percent of children in the custody of their parents are still in parental custody when cases close; but in 60 percent of the Help for Children cases in which parents did lose custody, children moved into a residential school or a group home.

¹⁴ The Department of Social Services 1988-1989 Comprehensive Needs Assessment, for example, found the need for substitute care services, particularly community residences for adolescents, exceeded its availability.

Of state human service agencies, the Department of Social Services (DSS) is most likely to pay for the residential care provided to Massachusetts children. DSS requires parents to give the agency "voluntary" custody, if the child is not already in its custody, before funding the placement.

Voluntary changes of custody to the Department of Social Services were recorded for 123 cases in 1988. 2.5 percent of the closed child cases with the relevant information coded. In these cases:

- 76 children (62 percent) moved into a residential school,
- 23 children (19 percent) went into foster care,
- 8 children (7 percent) went to other placements,
- 3 children (2 percent) went home, and
- 13 children (11 percent) did not change residence.

Although half of the children with a voluntary change of custody who went to residential schools moved there from home, almost 40 percent moved from more restrictive psychiatric placements. Ironically, parents had retained custody during the more restrictive placements.

DSS is reevaluating its voluntary custody policies. Whenever possible, the agency will offer parents the opportunity to sign a partnership agreement. The agreement would spell out the Department's and the parents' responsibilities for children in residential facilities.

Advocates should look closely at this partnership concept, and support steps by state agencies and residential facilities that encourage parents to retain custody and strengthen their caretaking roles and abilities while the child is in placement. The partnership agreement policy has been discussed primarily as an option for parents of children with mental retardation and other developmental disabilities. Its applicability to families of children with mental health problems should also be examined.

An additional issue that contributes to parents losing touch with their children during placement may be finances. Families who have received disability payments through the Social Security Administration turn them over to the Department of Social Services when the child is in placement. The family, however, may continue to have financial needs, for example, for transportation or to prepare for the child's return home.

OLDER ADOLESCENTS

OVERVIEW

Any child in Massachusetts is eligible for OFC's Help for Children program until he or she turns 18 years of age. However, if a child has special needs, he or she remains eligible for HFC services until his or her twenty-second birthday. About six percent of the 1987 and 1988 HFC advocacy cases involved youth in the older age group: 472 requests in 1987 and 397 requests in 1988, a 15.3 percent decrease.

In virtually all of these cases, the adolescents involved had at least one diagnosed impairment. In both years, mental retardation emerged as the primary impairment in about one third of the cases, compared to a rate of about seven percent in cases involving children under 17 years of age.

Nearly 55 percent of the older adolescent cases involved clients diagnosed as having two or more impairments. In comparison, only 35 percent of the overall case load in 1988 and 25 percent in 1987 represented children with two or more impairments.

Parents, guardians, and professionals requested out-of-home placements in 29.7 percent of the 1988 cases and 32 percent of the 1987 cases involving older adolescents. The type of placement requested is detailed in the following table.

**FIGURE 12: OUT-OF-HOME PLACEMENT REQUESTS FOR
18 TO 21 YEAR OLDS**

TYPE OF PLACEMENT	1987	1988
Residential School/Group Home	47	54
Chapter 766 502.6 Prototype	41	20
Supervised Apartment	23	16
DMH Community Residence	14	9
DMH Residential Treatment Facility	11	4
Psychiatric Hospital	10	5
Other	8	7
TOTAL	154	115

All of the cases involving older adolescents referred to the Central Team represented requests for out-of-home placement. Most of the older adolescents in Central Team cases

were diagnosed with mental retardation and emotional/behavioral disorders or other impairments.

The services needed by older adolescents differ from those required by younger children and adolescents. While some of these young people may never be able to live independently, most older adolescents, including some served by Help for Children, can be successful in attaining independence as adults. To do so, they must redefine their status in their own families and move into the larger community to work and live on their own.

INDEPENDENCE OR LIFE LONG SUPPORT

One group of older adolescents served by Help for Children require a variety of supportive services, including living arrangements designed to help them learn how to live on their own.

BRIAN

When Brian was 16 years old, the principal of his school recommended that the court assign custody to the state Department of Youth Services (DYS). The principal, concerned about Brian's family situation and his parents' ability to care for him, had not been able to get the kind of help Brian needed through the Department of Social Services.

DYS placed Brian in a local group home so that he could continue to attend the same school. While living in the group home, Brian made significant progress and performed extremely well in school, at the group home, and at his part-time job.

Brian's case came to Team when he reached 18 years of age. Because of his age and the fact that he was doing so well, DYS had decided to close his case and DSS had refused to reopen it. A return home was not feasible.

Brian needed a place to live until he graduated from high school. He had already been accepted by the military pending graduation. Team intervened and assigned DSS and DYS joint responsibility for Brian's placement. This allowed him to make a successful transition from the group home into adult life.

A second group, some of whom could be cared for at home when they were younger, will never be able to live fully independently.

HARRIET

Harriet was 19 years old and lived at home with her aging mother. Mentally retarded with mild cerebral palsy, she attended a local special education day program where she did well. When she went away to her respite care program, she behaved well. However, at home, inconsistent care resulted in tantrums and other problems.

Harriet was about to go home after a stay at the respite program when her mother decided she could no longer handle her and refused to let her come home. Harriet's history, her inability to take care of herself, and need for a structured environment called for a permanent supported living situation. The Central Team assigned responsibility for her residential placement to the Department of Mental Retardation.

When their cases are closed, nearly half of the older adolescents served by Help for Children are living independently. One-third are still in their parents' custody, 12 percent have guardians after age 18, and seven percent are in the custody of a state agency, usually DSS.

FAMILY SUPPORT: CAUTIONARY REMARKS

Family support advocates must remember that as adolescents approach chronological adulthood, their families may not be able to provide for them — even with in-home support services. For a variety of reasons, home-based services may no longer be appropriate:

- Problems, inadequately addressed or ignored, may worsen. By older adolescence, crises are likely to develop.
- Parents who have managed to care for children at home with or without supports, are growing older, too. They may become ill or otherwise unable to manage.
- Behavior patterns, which could be controlled when the child was younger and smaller, may become dangerous as the child reaches adult size and strength.
- Gaining independence may be important for the adolescent.

At the same time, families may find it particularly difficult to obtain support services such as case management or residential placements for older adolescents.

- Resources are limited. In 1988, the interagency team that serves southeastern Massachusetts handled ten cases involving older adolescents with emotional and behavioral problems who needed continued residential placement. They found only five residential schools in the state which were approved as special education facilities by the Department of Education and would accept clients in this age range.
- The developmental age of these children usually does not match their chronological age. Some are children in adult-size bodies. Older adolescents need services that may only be available through an agency that serves children or the children's unit of an agency that serves adults. Conversely, assumptions that guide children's services—such as the possibility of parental care—may no longer be appropriate.

- The agencies that serve older adolescents who have special needs under the category of children's services may only do so if the child was a client of that agency prior to his or her eighteenth birthday. These agencies also may give clients served by them before age 18 priority in practice, particularly for case management and residential services.

Family support advocates must acknowledge that older adolescents and their families have needs which are distinct from those of younger children and their families. Service plans must assume that eventually a child will need a permanent living arrangement that is not dependent on a parent.

Caretakers, whether they are parents, foster parents, or residential providers, can help prepare adolescents for independence. They need training and support to accomplish this critically important task, particularly when adolescents have disabilities or difficult family histories. In other cases, a flexible system of service coordination geared to moving older adolescents into the adult care system according to their developmental needs is required.

RESPONSIBILITY FOR PLACEMENT

While the focus of the delivery system should shift to home based services, out-of-home residential placement cannot be neglected. Details such as which agency assumes responsibility may affect the type and availability of programs as well as the development of home-based alternatives.

Help for Children data reflect changes that have occurred in the residential placement responsibilities of various human services agencies and school districts over the past two or three years. The state, through the Department of Education, assumed fuller and more direct responsibility for funding residential educational placements (502.6 prototypes) required under the state's special education law, Chapter 766. As already discussed, requests for help in approaching school districts to approve these placements decreased. In addition:

- When residential school or group home placements were requested, the Department of Social Services (DSS) provided services in 8.7 percent more cases closed in 1988 than it did in 1987. The Department of Mental Health (DMH) provided services in 2.4 percent fewer cases.
- Between 1987 and 1988, substantial change occurred in the number of requests for placements for which DMH is responsible. Requests for DMH residential treatment dropped from 72 to 28 (61 percent), while those for psychiatric hospitalization declined from 66 to 55 (16 percent). Those seeking placement in a DMH community residence, while small in number, increased from 13 to 16.
- When psychiatric hospitalization was requested, DMH provided services in 7.4 percent more cases closed in 1988 than in 1987. In 1988, DMH and DSS each funded 25 percent of the psychiatric hospitalizations requested; private agencies provided the remaining 50 percent.

Exploring these changes highlights additional family support issues. Several factors, including changes in policy and the way services are organized occurred in 1987 and 1988; and seem relevant:

- DSS has provided the bulk of group home, residential school and other placements for abused and neglected children, and for children with other family problems, disabilities, histories of suicide, and what many would describe as "mental health" problems.
- DSS has a broad mandate. It provides residential services for some children and families that one might expect would be the responsibility of agencies which focus on more specialized populations. When the Department of Mental Retardation (DMR) split from DMH and began offering limited services in 1988, an interim interagency agreement stated that DSS would continue to provide residential services for children in its caseload with mental retardation while the new Department developed its resources, administrative structure, and policies.
- In 1988, DMH began taking steps to assume full responsibility for psychiatric hospitalization and an interagency agreement was signed in May of 1989.
- In 1988, DMH clarified its definition of service eligibility to focus its resources on "serious" emotional disorders and severe mental illness. The definition fit children with diagnoses such as schizophrenia and paranoia. Children with diagnoses of "adolescent adjustment syndrome" or nonspecific behavioral disorders were "picked up" by DSS.
- DMH was also under a July 1, 1989 deadline to move children from adult psychiatric wards. They gave priority to placing these children.
- Medicaid funded beds were created in psychiatric hospitals through the "Psych under 21" bill.

These shifts and many other factors complicate the interpretation of Help for Children data. Whether increases and decreases in requests for advocacy reflect changes in children's needs remains unclear. For example, there were fewer requests for psychiatric hospitalization. Clearer targeting of children and the development of additional resources probably had an affect on this category, but can fewer advocacy requests be interpreted as reduced need? It is important to note that:

- Changes were not uniform by age and type of placement. For example, for 11 to 14 year olds, psychiatric hospitalization requests increased slightly.
- DSS serves children that most professionals would consider to have mental health needs, albeit of a different kind than those served by DMH. If children need psychiatric hospitalization but do not fit DMH's client profile, they may be difficult to place.¹⁵

¹⁵ DMH has recently agreed to assess all children for psychiatric hospitalization, including those in DSS care and custody. This agreement may facilitate psychiatric hospitalizations, when they become necessary.

An assessment of the number of beds needed in different types of residential settings would help planners target resources, assist children in securing appropriate and timely services, and likely prove cost effective for the state. The shortage of less restrictive settings and the lack of home based supports may create some of the demand for residential school placements.

At the same time, policy makers should discuss and clarify the division of responsibility for placement. Included for discussion should be responsibility for children with mental retardation and other developmental disabilities, as well as those with mental illness, less specific emotional or behavioral disorders and chronic family problems.

How questions about responsibility for out-of-home placement are resolved can affect the development of home-based services and other types of family support. For example:

- If an agency is responsible for funding the continuum of services, it may be more likely to investigate the relative effectiveness and costs of various services in the continuum.
- An agency offering a continuum of services may be more willing to support changes in how human service funding is earmarked, changes that would encourage the development of home based and preventive services.
- A "continuum" agency may be more aware not only of the in-home alternatives that work, but also of the signs that a residential placement is necessary.

On the other hand:

- Either home-based or residential services may be shortchanged if an agency is responsible for the full continuum but funding is insufficient.
- The needs of a lower incidence population may drop far down on the list of agency priorities if the agency typically serves children, or adults, with a number of different problems.
- Placing different types of services or services for different populations in separate agencies may allow for clearer documentation of the need for the full continuum, with each agency representing its own share of clients.

Policy makers should factor these and other family support considerations into future discussions.



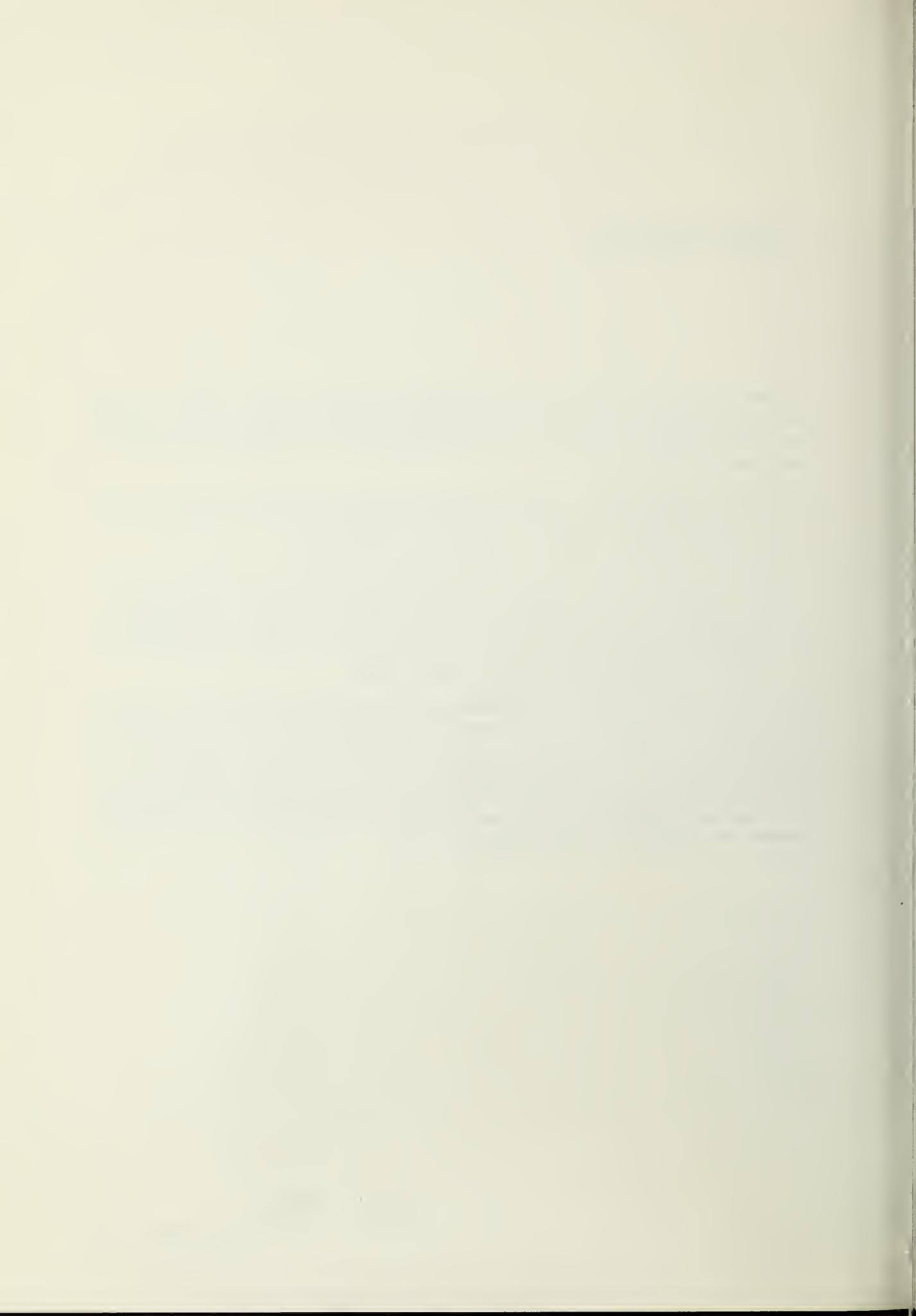
CONCLUSION

Without abandoning its role as advocate for children who are at risk, in crisis, or in need of out-of-home placement, the Office for Children's Help for Children Program can and must focus additional energy on accessing prevention, early intervention, and home based services for children.

Developing a comprehensive network of these preventive services will require the creative use of existing resources, close collaboration among the state agencies that serve children, and cooperation between the public and private sectors.

Although a somewhat lesser issue in fiscal years 1987 and 1988, any discussion involving a shift in emphasis to prevention must take into account the state's current fiscal situation. Large scale program development in the near future is doubtful. Despite the fact that preventing problems will save money in the long run, diverting funds from crisis intervention and treatment may not be a realistic choice.

Therefore, it is time to examine the children's service delivery system from a new angle, the family support perspective. This report is a beginning. The family support outlook will require us to take a new look at how we use the resources we have and how we promote self-reliance in families. Prevention can save lives and money. Home-based services, depending in their type and the length of time they are needed, may also cost less than maintaining a child in a group home or institution. Most important, they will enable children who need them to have a home and family.





COMMONWEALTH OF MASSACHUSETTS

Michael S. Dukakis, Governor

Philip W. Johnston, Secretary of Human Services

Mary Kay Leonard, Commissioner

